New Hampshire Department of Health and Human Services, Division of Public Health Services
West Nile Virus Surveillance: Encephalitis/ Meningitis Initial Case Report Form

PATIENT INFORMATION

Last Name_____ First Name _____ MI____ County ____ _____
Address _____City _____ State____ Zipcode _____
Telephone - H (____)_____-_____ W (____)_____-_____ Date of Birth ____/____/____ Age_____
Occupation:_____ Sex: _ Male _ Female__ Pregnant? _ Yes _ No _ Unknown__
Race: White _ Black__ Am Indian/Alaskan__ Asian__ Other__ Ethnicity: Hispanic__ Non-hispanic _ ----Unk__

CLINICAL INFORMATION

Hospitalized? Yes __ No__ If yes, Hospital Name_____ City_____
Date of admission ____/____/____ Date of discharge/transfer ____/____/___
Date of first symptoms ____/____/____ Date of first *neurologic* symptoms ____/____/____
Current Diagnosis: __ encephalitis__ meningitis ___ Other_____
Fever (> 38 C or 100 F) __ Yes __ No __ Unknown Altered mental status__ Yes __ No __ Unknown
Headache __ Yes __ No __ Unknown Stiff neck/Meningeal signs __ Yes __ No __ Unknown
Seizures __ Yes __ No __ Unknown Muscle weakness __ Yes __ No __ Unknown
Rash __ Yes __ No __ Unknown Muscle pain __ Yes __ No __ Unknown
Other neurologic signs __ Yes __ No __ Unknown Joint pain __ Yes __ No __ Unknown
Other symptoms (current or 1 month before onset)_____ _____
Outcome __ Recovered __ Died __ Unknown If patient died, date of death ____/____/____
ANTIVIRALTREATMENT _ Yes _ No _ Unk If yes, list below. **Date started:**
_____ _____--

LABORATORY INFORMATION / TEST RESULTS

CSF (specify units) Collection Date ____/____/____ Abnormal? __ Yes __ No __ Unknown
Glu _____ Prot _____ RBC _____ WBC _____ Diff: Segs% _____ Lymphs%_____
Gram stain _____ Bacterial Culture _____ Fungal / Parasitic tests _____
Viral test results (Culture/ Serology / PCR) _____
Serum Collected Date:___/___/___
CBC (specify units) Date ____/____/____ WBC _____ Diff: Segs% _____ Lymphs% _____
MRI Date ____/____/___ Result_____
CT Date ____/____/___ Result_____
EMG Date ____/____/___ Result_____

RISK FACTOR INFORMATION during **1 month** before onset of Sx.

	Yes	No	Location (if yes)	Dates (if yes)	Unknown
Travel outside county of residence?					
Travel outside New Hampshire?					
Travel outside country?					

Organ transplant/ blood transfusion recipient? Yes____ No____

Animal or arthropod contact? Yes __ No __ Unk___ Specify: _____

REPORTED BY:

Last name _____First name _____Title (ICN, Resident, Attending) _____
Work address_____ City _____State___ Zip Code _____
Telephone (____)_____-_____ Pager (____)_____-_____
Date of Report: ___/___/___

This form must be faxed to the New Hampshire Communicable Disease Control Section (603-271-0545) *and* a copy submitted with the laboratory specimen(s) to the NH PHL.

FOR NH COMMUNICABLE DISEASE CONTROL SECTION USE:

Initial Report taken By:_____ Report Completed By :_____
Acquired in NH __ Acquired in another state __ Acquired outside US __ Unknown__
Case Status : __ Confirmed __Probable __Not a case __Unknown __ Other State